

February 1997

Medicare





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**Comptroller General
of the United States**

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The President of the Senate

The Speaker of the House of Representatives

In 1990, the General Accounting Office began a special effort to review and report on the federal program areas its work identified as high risk because of vulnerabilities to waste, fraud, abuse, and mismanagement. This effort, which was supported by the Senate Committee on Governmental Affairs and the House Committee on Government Reform and Oversight, brought a much-needed focus on problems that were costing the government billions of dollars.

In December 1992, GAO issued a series of reports on the fundamental causes of problems in high-risk areas and, in a second series in February 1995, it reported on the status of efforts to improve those areas. This, GAO's third series of reports, provides the current status of designated high-risk areas.

This report discusses the challenges that the federal government faces in safeguarding Medicare, the government's second largest social program. Since the issuance of GAO's 1995 high-risk report, both the Congress and the Health Care Financing Administration, the agency responsible for running Medicare, have made important legislative and administrative changes addressing chronic payment safeguard problems. However, because of the hundreds of billions of dollars at stake, GAO believes that

the government will need to exercise constant vigilance and effective management to protect Medicare from waste, fraud, abuse, and mismanagement.

Copies of this report series are being sent to the President, the congressional leadership, all other Members of the Congress, the Director of the Office of Management and Budget, and the heads of major departments and agencies.

A handwritten signature in black ink, reading "James F. Hinchman". The signature is fluid and cursive, with a large initial "J" and a long, sweeping underline.

James F. Hinchman
Acting Comptroller General
of the United States

Contents

Overview	6
Background	12
Fee-for-Service Program Risks	15
Managed Care Program Risks	38
What Needs to Be Done	49
Related GAO Products	50
1997 High-Risk Series	53

Overview

Medicare provides health care insurance for nearly all elderly Americans (those age 65 and older) and many of the nation's disabled. It is one of the largest entitlement programs in the federal budget. In fiscal year 1996, federal spending for Medicare was \$197 billion. Program expenditures have been growing at about 9 percent per year. While growth has moderated somewhat during the last 2 years, many view even the lower growth rates as unsustainable. Moreover, the trust fund that pays for hospital and other institutional services is projected to be depleted within 5 years. The Congress and the President have been seeking to introduce changes to Medicare to help control program costs. At the same time, they are concerned that significant amounts of these costs are lost to fraudulent and wasteful claims.

Although no one can claim with precision how much Medicare loses each year, our work suggests that by reducing unnecessary or inappropriate payments, the federal government would realize large savings and help dampen the growth in Medicare costs. The hidden nature of improper billing and health care crimes precludes a rigorously quantified estimate of expenditures attributable to fraud and abuse. Estimates of

the costs of fraud and abuse ranging from 3 to 10 percent have been cited for health expenditures nationwide, so applying this range to Medicare suggests that such losses in fiscal year 1996 could have been from \$6 billion to as much as \$20 billion.

Most Medicare services are provided through the fee-for-service sector, where any qualified provider can bill the program for each covered service rendered. In recent years, greater numbers of Medicare beneficiaries have enrolled in health maintenance organizations (HMO) to receive covered services. The most recent figures show, however, that almost 90 percent of beneficiaries remain under the fee-for-service program. Each of these delivery systems has its unique set of problems.

In 1992 and again in 1995, GAO reported on Medicare as one of several government programs highly vulnerable to waste, fraud, abuse, and mismanagement.¹ Since the first report in the series, the Health Care Financing Administration (HCFA), the Department of Health and Human Services' (HHS) agency responsible for running the

¹High-Risk Series: Medicare Claims (GAO/HR-93-6, Dec. 1992) and High-Risk Series: Medicare Claims (GAO/HR-95-8, Feb. 1995).

Medicare program, has made some regulatory and administrative changes aimed at curbing fraudulent and unnecessary payments. However, in recent years, sizable cuts in the budget for program safeguards, where most of the funding for the fight against abusive billing is centered, have diminished efforts to thwart improper billing practices.

Problems

Problems in funding program safeguards and HCFA's limited oversight of contractors continue to contribute to fee-for-service program losses. While HCFA expects a major system acquisition project to reduce certain weaknesses, the project itself has several risks that may keep HCFA from attaining its goals. In addition, the managed care program suffers from excessive payment rates to HMOs and weak HCFA oversight of the HMOs it contracts with. These flaws leave beneficiaries without information essential to guide their HMO selection and without assurance that HMOs are adequately screened and disciplined for unacceptable care.

Progress

Since GAO's last high-risk report in 1995, the government has made important strides in efforts to protect Medicare from

exploitation. Recent legislation—the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), popularly known as the Kassebaum-Kennedy Act—increases funding for program safeguards, although per-claim expenditures will remain below the level of 1989 after adjusting for inflation. Nevertheless, we expect that the increase, if properly applied, can significantly improve anti-fraud-and-abuse efforts. In addition, HCFA anticipates that it will gain enhanced oversight capacity and reduced administrative costs when the next-generation claims processing system—the Medicare Transaction System (MTS), now progressing through its design phase—is fully implemented, which HCFA expects to occur after the year 2000. Further, the HHS Inspector General and other federal and state agencies have banded together to fight fraud in five states in an effort called Operation Restore Trust. After the first year of operation, the effort yielded more than \$40 million in recoveries of payments for claims that were not allowed under Medicare rules, as well as convictions for fraud, impositions of civil monetary penalties, and the exclusion of providers from the program.

Progress is also being made in addressing program management issues. For example,

the Health Insurance Portability and Accountability Act gives additional flexibility to HCFA to contract with firms specializing in utilization reviews and makes more severe the penalties for Medicare fraud. In addition, HCFA is improving its credentialing process for Medicare providers and is currently evaluating commercially available software for its potential to screen out some types of inappropriate claims. Finally, the new Health Insurance Portability legislation and several planned consumer information efforts offer the potential for improved HCFA oversight of HMOS.

Outlook for the Future

Many of Medicare's vulnerabilities are inherent in its size and mission, making the government's second largest social program a perpetually attractive target for exploitation. That wrongdoers continue to find ways to dodge safeguards illustrates the dynamic nature of fraud and abuse and the need for constant vigilance and increasingly sophisticated ways to protect against gaming the system. Judicious changes in Medicare's day-to-day operations entailing HCFA's improved oversight and leadership, its appropriate application of new anti-fraud-and-abuse funds, and the mitigation of MTS acquisition risks—these are

necessary ingredients to reduce substantial future losses. Moreover, as Medicare's managed care enrollment grows, HCFA must ensure that payments to HMOs better reflect the cost of beneficiaries' care, that beneficiaries receive information about HMOs sufficient to make informed choices, and that the agency's expanded authority to enforce HMO compliance with federal standards is used. To adequately safeguard the Medicare program, HCFA needs to meet these important challenges promptly.

Background

Congressional attention has recently been focused on the impending depletion of Medicare's Federal Hospital Insurance Trust Fund. Payroll taxes credited to the hospital trust fund finance the bulk of Medicare's "hospital insurance," or part A, which covers nursing facility, hospice, and home health care in addition to inpatient hospital services. Current projections by the fund's trustees indicate that, absent action, it will be insolvent by 2001. Beneficiaries' premium contributions and general revenues finance Medicare's "supplementary medical insurance," or part B, which covers physician and outpatient hospital services, diagnostic tests, and ambulance and other medical services and supplies. Although the part B trust fund's link to the Treasury shields it from the danger of bankruptcy, part B expenditures comprise a growing share of the federal budget.

HCFA administers Medicare largely through an administrative structure of claims processing contractors. In 1965, when the Medicare program was enacted, the law called for insurance companies—like Blue Cross and Blue Shield, Travelers, and Aetna—to process and pay claims because of their expertise in performing these functions. As Medicare contractors, these

companies use federal funds to pay health care providers and beneficiaries and are reimbursed for their administrative expenses incurred in performing the work. Over the years, HCFA has consolidated some of Medicare's operations, and the number of contractors has fallen from about 130 to about 70 in 1996. Generally, intermediaries are the contractors that handle part A claims submitted by "institutional providers" (hospitals, skilled nursing facilities, hospices, and home health agencies); carriers are those handling part B claims submitted by physicians, laboratories, equipment suppliers, and other practitioners.

HCFA's efforts to guard against inappropriate payments have been largely contractor-managed operations, permitting the carriers and fiscal intermediaries broad discretion in acting to protect Medicare program dollars. As a result, there are significant variations in contractors' implementation of Medicare's payment safeguard policies. In 1996, the budget for contractors to administer Medicare was approximately \$1.6 billion, with 24 percent devoted to payment safeguard activities.

From a management perspective, Medicare consists of two programs—fee-for-service

and managed care. The fee-for-service program covers most of the program's beneficiaries—almost 90 percent, or 33 million individuals in 1996. Physicians, hospitals, and other providers submit claims to Medicare to receive reimbursement. In contrast, Medicare's managed care program covers a much smaller number of beneficiaries—nearly 5 million in 1996. It is funded from the part A and part B trust funds. The managed care program consists mostly of risk contract HMOs,² which enrolled about 4 million Medicare beneficiaries in 1996. Physicians, hospitals, and other providers serving these HMOs' enrollees do not submit a per-service claim for reimbursement. Instead, they are paid by the HMO, which in turn is paid a monthly amount by Medicare for each beneficiary enrolled. This amount is fixed in advance. In this sense, the HMO has a "risk" contract because regardless of what it spends for each enrollee's care, the HMO assumes the financial risk of providing health care within a fixed budget. HMOs profit if their cost of providing services is lower than the predetermined payment but lose if their cost is higher than the payment.

²Other Medicare HMOs include cost contracts and health care prepayment plans. Cost contract HMOs allow beneficiaries to choose health services from an HMO network or outside providers. Health care prepayment plans may cover only part B services. Together, they enroll fewer than 2 percent of the Medicare population.

Fee-for-Service Program Risks

The depletion of Medicare's hospital trust fund and the projected growth in Medicare's share of the federal budget have focused congressional attention on making broad program reforms. Although the consensus to make changes is clearly building, there is less agreement about what the changes will be, when they will be implemented, and whether they will be comprehensive or incremental. For the near term, Medicare's current structure is likely to remain in place; therefore, we have made the existing program's day-to-day management the focus of this report.

Certain factors make Medicare's fee-for-service program inherently high risk. For one thing, health care consumers are less alert to provider charges when a third party pays most of their bill. In Medicare, even when patients receive a notice of what services their provider billed, the computer-generated notices can be difficult to follow.

In addition, guarding against waste, fraud, and abuse in a program the size of Medicare would task any payer: fee-for-service Medicare serves about 33 million beneficiaries and processes a high volume of claims—over 800 million in 1996—from

hundreds of thousands of providers. Individually, the claims tend to be for relatively low dollar amounts, so balancing the extent of scrutiny given each claim against the costs and benefits obtained is important.

Compounding these difficulties has been a pattern since 1989 of unstable funding for anti-fraud-and-abuse activities. However, passage of the Health Insurance Portability and Accountability Act adds new funds—starting in 1997—to fight fraud and abuse. By 2003, funding for anti-fraud-and-abuse activities will have increased over the 1996 level by about 80 percent. This increased funding offers the promise of much-needed improvements.

**Decline in Funds
for Safeguarding
Payments
Weakened Efforts
to Deny Improper
Claims, Deter
Abuse**

Since 1989, the number of Medicare claims has climbed 70 percent to 822 million in 1996. During that same period, however, resources committed to claims review, both before and after payment, without adjusting for inflation, grew less than 11 percent. Under these circumstances, the amount contractors could spend for reviewing claims shrank from 74 cents to 48 cents per claim, at a time when payments for part A benefits more than doubled. In 1995, only

about 3 percent of Medicare's part A claims on average received more than superficial screening before being paid. This scarcity of resources seriously hampered the Medicare contractors' efforts to (1) conduct various reviews of claims to verify beneficiaries' needs for the services billed and (2) audit providers' cost reports to ensure that reimbursed costs meet standards for reasonableness and appropriateness.

The inadequate funding of Medicare's claims scrutiny activities has hurt contractors' efforts to review the medical necessity of services billed to the program. Contractors review some portion of their total claims volume at both the prepayment stage—while the claims are being processed—and at postpayment—after the payment checks have been sent out. Medicare's review of home health claims illustrates the effect of reduced review that resulted from constraints on the contractors' payment safeguard budgets since 1989.

In 1985, legislation more than doubled the funds available for reviewing home health and other claims. Contractors reviewed for medical necessity 62 percent of home health claims processed in fiscal years 1986 and 1987. In contrast, since 1989, contractors'

claims review target was lowered to 3.2 percent (or even lower, depending on available resources, to a required minimum of 1 percent). At the same time, the home health claims volume more than tripled between 1989 and 1994, from 5.5 million to 16.6 million.

In 1996, we reported that, because of the small number of claims selected for review, home health agencies billing for noncovered services were less likely to be caught. Besides covering so few claims, prepayment reviews of home health claims done at the contractor's office are simply paper reviews and, therefore, limited in their ability to detect noncovered care. If billing codes appear valid, forms appear to be filled out correctly, and the services billed have not been flagged for additional attention based on the results of other analyses, the claim goes through without further scrutiny. In the case of a large home health organization we investigated, claims passed review scrutiny even for visits never made, because company staff allegedly falsified the medical records. Contractors have also noticed instances where the wrong diagnosis has been put on the claim form to give the impression that beneficiaries are sicker and

in need of more care than is actually the case.

The lack of adequate resources also prevented contractors from conducting effective postpayment reviews of home health claims. In Medicare, comprehensive medical reviews are an essential component of postpayment reviews of home health agencies and entail evaluations of claims and medical records, such as plans of care and documentation of visits. In 1994, fewer than 1 percent of all Medicare-certified home health agencies received on-site comprehensive reviews. Because these reviews are resource intensive and because contractors are required to do only 10 annually for all provider types combined—including outpatient, skilled nursing, and rehabilitation facilities—a contractor may not do any for home health agencies if they account for a relatively small portion of the contractor's total claims volume. In fiscal year 1994, for example, the number of on-site audits ranged from none to 15 among the nine contractors responsible for reviewing home health claims. Declines in funding also weakened the efforts of contractors to do prepayment reviews of part B claims. In 1991, HCFA required contractors to conduct prepayment reviews

of 15 percent of part B claims, whereas by 1995 the required level had sunk to 4.6 percent.

A successful HCFA demonstration project, which we reported on in 1994, helps explain how adequate funding of part B contractors' claims review activities can reduce program losses. In the demonstration, HCFA gave three part B Medicare carriers a 12-percent increase in funds to do claims review activities, while two "comparison" carriers received no additional funding. Over the life of the project, each demonstration carrier saved about twice as much as the two comparison carriers in the project, or \$2.84 per claim compared with \$1.34 per claim. The financial investment in claims review permitted the demonstration carriers to employ over twice the number of claims review staff employed by the comparison carriers and to employ staff technically qualified to do data analyses, use four times more computerized controls to flag questionable claims for review, and review before payment nearly four times the volume of claims.

Another payment safeguard activity impaired by funding declines involves cost report audits, which are Medicare's principal

weapon to fight the shifting of inappropriate or unnecessary costs to the program. Providers paid under Medicare's cost-based reimbursement systems—such as hospital outpatient departments, skilled nursing facilities, and home health agencies—are reimbursed not on the basis of a fee schedule or the charge for a service but on the basis of the actual cost to provide the service.

Reimbursement to institutional providers occurs in several steps. First, Medicare contractors make periodic “interim” payments based on the provider's historical costs and current cost estimates. These payments help defray the ongoing costs of providing services to Medicare beneficiaries. Second, at the end of each year, the providers submit reports that detail their operating costs throughout the preceding year and specify the share related to the provision of Medicare services. Using this information, intermediaries make tentative settlement payments or recover excessive payments based on the total amount claimed and the amounts already paid in interim payments. Third, the intermediary can conduct a more detailed review of the cost reports to determine the appropriate final settlement amounts, but in practice, only a

fraction of providers is subject to such reviews and the number has declined in recent years. Between 1991 and 1996, the chances, on average, that an institutional provider would be subject to a detailed review fell from about 1 in 6 to about 1 in 13.

Furthermore, because of the time needed to schedule and conduct audits, intermediaries can take 2 years or more to make this review and final settlement. Tentative settlements that differ substantially from the amount ultimately determined to be due a provider cause underpayments or excessive payments that can remain outstanding for 2 years or more. When excessive payments occur, Medicare loses interest income because it has less surplus trust fund money to invest in government securities.

**Significant
Management
Problems
Remain,
Independent of
Funding
Adequacy Issues**

As we noted in reports and testimonies in recent years, HCFA has been less than aggressive in managing the Medicare claims processing function. HCFA has not taken a leadership role, for example, in managing how contractors select the criteria used to identify claims that may not be eligible for payment or in assisting contractors in this task. In addition, HCFA's acquisition of a major new claims processing system has

several flaws that, if not corrected, put the system at risk of not meeting touted expectations. Interim information management activities also pose certain risks.

Absence of
Coordinated Claims
Screening Strategy

Generally, when contractors process Medicare claims, the claims are run through computerized screens, or edits, to detect such problems as incomplete or inaccurate provider billing numbers and beneficiary identification numbers, duplicate claims, and beneficiary ineligibility. Contractors have additional “medical necessity” screens that flag claims for not meeting certain diagnosis or frequency-of-treatment criteria and suspend payment until further review. The criteria are established in contractors’ medical policies, which, with some exceptions, are developed locally and vary greatly among contractors.

HCFA has not systematically aggregated information on contractors’ medical policies or their related use of prepayment screens. As a result, HCFA has not adequately assessed the relative performance of contractors or helped share with all contractors the experience of some in using effective claims screening controls. HCFA’s current approach

is to rely on contractors to focus their reviews on overutilization problems that are local.

Our 1995 review of 17 contractors' use of medical necessity screens for Medicare's high-volume medical procedures illustrates HCFA's lack of a coordinated approach. For example, 10 of the 17 contractors reviewed lacked screens for echocardiography, which in fiscal year 1994 was the most costly diagnostic test in terms of total Medicare payments and which increased in use nationwide by over 50 percent between 1992 and 1994. Eleven of the contractors were not screening colonoscopy claims by the end of 1994, despite the advice of the HHS Inspector General in 1991 to monitor the use of colonoscopies and deny claims that were not indicated by medical symptoms or supported with documentation. We estimated that Medicare could have denied at least \$10.5 million in echocardiography payments and \$5.8 million in colonoscopy payments made in 1993 if just seven contractors that did not screen these procedures had applied the medical necessity screens used by the other contractors. We also estimated that medical necessity screens for all six procedures tested—eye exams, chest X rays, yttrium aluminum garnet (YAG) laser surgery,

and duplex scan of extracranial arteries in addition to echocardiography and colonoscopy—could have saved Medicare from \$29 million to \$150 million in payments made by these seven contractors for services that may have been medically unnecessary. The range reflects the variation in contractors’ criteria for identifying medically unnecessary services.

Implementation of
Major Claims
Processing System
at Risk

We have also reported in recent years on HCFA’s acquisition and development of a claims processing system called the Medicare Transaction System. HCFA intends MTS to replace the nine different claims processing systems it currently uses by the year 2000. The goals of MTS are to provide enhanced claims processing capabilities, increased levels of beneficiary and provider service, and greater capabilities to provide program safeguards. Overall, HCFA expects the system to process over 1 billion claims and pay \$288 billion in benefits in the year 2000.

In January 1994 and November 1995, we reported on risks associated with the MTS project. In response to our work, HCFA revised its initial MTS approach from developing and installing the system in a

single stage to developing, testing, and implementing MTS through a number of clearly defined system releases, thereby reducing the potential for problems stemming from large-scale system failures. While this new approach should facilitate managing the MTS project, we identified critical management and technical risks that could result in a system that does not meet HCFA's needs. First, difficulties in defining requirements have led HCFA to redirect its approach to this effort twice. HCFA is now working to completely define its requirements. Inadequately defined requirements could cause technical problems. Second, HCFA's MTS development schedule showed significant overlap among the various system-development phases. Progressing with succeeding phases before the previous phase has been completed also increases the risk that technical problems will occur. Finally, our previous review of HCFA's cost benefit analysis of MTS found it flawed and warranting corrections before HCFA can use it to make effective management decisions.

HCFA is working on the reported deficiencies. We plan to evaluate HCFA's efforts after it completes this work.

Other Potentially
Troublesome
Information
Management Issues

Before MTS is completed, HCFA must oversee several essential information management transitions in the Medicare claims processing environment. One transition involves the shifting of claims processing workloads, either because a contractor, for business reasons, has opted to leave the program or because HCFA will have closed some claims processing sites and moved the work to remaining sites in an upcoming effort to consolidate claims processing. In 1992 and 1994, we reported on the consequences of poor planning when HCFA shifted an outgoing contractor's claims processing workload to another contractor's automated system. There were serious disruptions in getting claims processed and payments made to physicians, an increase in erroneous payments, and a decrease in payment safeguards that may have resulted in overpayments. In a second transition, to facilitate the implementation of MTS while reducing system maintenance costs, HCFA is planning to convert the contractors' claims processing systems—currently three part A and six part B systems—into a single part A system and a single part B system. This will involve several major software conversions. A third transition involves the “millennium” problem—revising computerized systems to accommodate the year-digit change to 2000.

HCFA does not yet have plans for monitoring contractors' progress in making their systems "millennium compliant." Each of these information management transitions will require HCFA's careful planning and focused attention.

New Health Insurance Act, Other Initiatives Improve HCFA's Arsenal for Fighting Fraud and Abuse

The outlook for Medicare's program safeguards budget appears brighter largely due to gradual funding increases provided for in the 1996 Health Insurance Portability and Accountability Act. In addition, Operation Restore Trust, an HHS antifraud initiative, has been implemented to identify and recover overpayments from providers who improperly billed Medicare. Other changes underway include HCFA's improved screening of Medicare providers and more focused attention on both hardware and software aspects of Medicare's claims processing system. (See table 1.)

Table 1: Summary of Major Government Initiatives to Improve Medicare Fee-for-Service

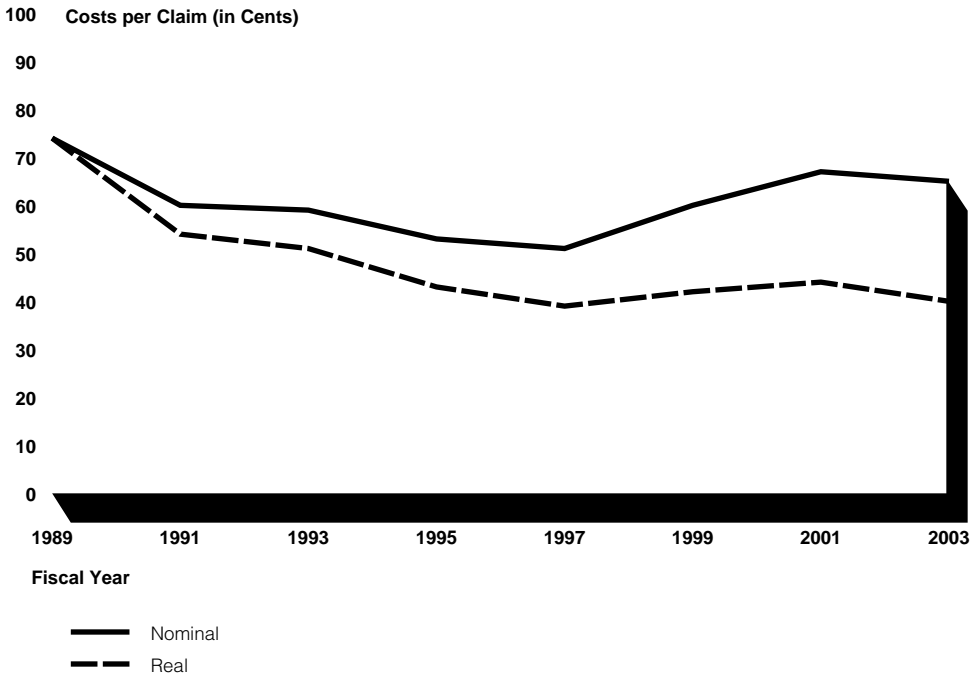
Problem area	Actions taken
Budget for anti-fraud-and-abuse activities	<p>Health Insurance Portability and Accountability Act: increases funding to investigate Medicare fraud and abuse and pursue the recovery of inappropriate payments.</p> <p>Operation Restore Trust: multiagency antifraud effort targeting high-use services provides increased funding for a 2-year period.</p>
Prepayment, prevention, and utilization review efforts	<p>HCFA's contract to acquire commercially developed software: explores whether the Medicare program can apply off-the-shelf software designed to detect unacceptable or inappropriately coded claims.</p> <p>Los Alamos interagency agreement: the Department of Energy's Los Alamos, New Mexico, National Laboratory is to provide HCFA with analytical and computer support to develop fraud and abuse detection methods, including enhancements in prepayment claims screening and postpay analyses.</p> <p>National Provider Identifier: HCFA has assigned numbers to every Medicare provider and supplier; effective in 1997, these numbers will be required for Medicare billing purposes.</p>
Contractor management and oversight	<p>Health Insurance Portability and Accountability Act: makes HCFA's authority explicit to contract with companies that specialize in utilization review, provider audit, and other safeguard activities to perform these functions for Medicare.</p>

Health Insurance Portability and Accountability Act of 1996

Most significantly, the Health Insurance Portability and Accountability Act increases the funding level for pursuing health care fraud and abuse, including HCFA's audit and related activities. For fiscal year 1997, the act boosts the contractors' budget for program safeguard activities to 10 percent higher than

in 1996; by 2003, the level will be 80 percent higher than for 1996, after which it remains constant. These additional amounts, however, will leave per-claim safeguard expenditures at about one-half the level of 1989 after adjusting for inflation (see fig. 1).

Figure 1: HCFA's Actual and Projected Per-Claim Program Safeguard Spending, FYs 1989-2003



Source: Justification of Estimates for Appropriations Committees, Fiscal Year 1996, HHS, HCFA (Washington, D.C.: 1996), section III, p. 58 and Economic Report of the President (Washington, D.C.: 1996), table B-56, p. 343.

In addition to funding, the act has several other provisions to improve vigilance over

Medicare benefit dollars, including the following:

- It allows HCFA to use additional contractors to perform utilization review, provider audit, and other safeguard activities as functions distinct from basic claims processing activities. The act permits HCFA to use separate claims processing and utilization review entities to avoid any conflict of interest and is intended to increase accountability and enhance data analysis capability.
- It establishes a program run jointly by the Department of Justice and HHS to coordinate federal, state, and local law enforcement efforts against fraud in Medicare and other health care payers. The program is to be funded by a new subaccount in the Medicare trust fund and the expenditure offset by having fines, forfeitures, and damages received as a result of the coordinated anti-fraud-and-abuse efforts transferred into the trust fund.
- It calls for greater information-sharing on health care fraud and abuse, including the establishment of a national health care fraud data collection program.
- It establishes enhanced penalties and specifies health care fraud as a separate criminal offense.

Operation Restore Trust

Operation Restore Trust is a 2-year antifraud initiative involving three HHS agencies—the Office of the Inspector General, HCFA, and the Administration on Aging—as well as the Department of Justice and various state and local agencies. HHS has designated an interdisciplinary project team of federal and state government representatives to target Medicare abuse and misuse in California, Florida, Illinois, New York, and Texas—states that together account for over one-third of all Medicare beneficiaries. The team has focused on three of the fastest-growing spending components: home health, nursing homes, and medical equipment and supplies.

In its first year, Operation Restore Trust reported recovering \$42.3 million in inappropriate payments: \$38.6 million were returned to the Medicare trust fund and \$3.7 million to the Treasury as a result of these efforts. It also resulted in 46 convictions, imposed 42 fines, and excluded 119 fraudulent providers. Inspector General officials believe that the major achievement of this initiative will be continued coordination among the various agencies involved and a heightened awareness of the effectiveness of constant vigilance. For example, as a result of improved

coordination between HCFA contractors and state surveyors in the project's several states, many of the targeted home health agencies were decertified and substantial sums in inappropriate payments were recovered. Operation Restore Trust is scheduled to be closed out as a demonstration project in May 1997.

HCFA's Efforts to
Adopt Fraud and
Abuse Detection
Software

HCFA has taken several actions to improve Medicare's fraud detection activities. In a 1995 study, we found that commercial systems, which analyze paid claims for patterns that identify potentially fraudulent providers, could significantly improve HCFA's ability to detect and prevent potential Medicare fraud. Our study found that Medicare's largest part B contractor had acquired this type of commercial antifraud technology and identified over \$6 million in potentially fraudulent payments. We also noted that although this technology had potential benefits, it was not being widely used in the Medicare program. Recently, HCFA expanded the use of commercial antifraud systems by providing about \$1 million to fund this technology at three additional Medicare contractor sites.

HCFA is aggressively pursuing another effort to strengthen Medicare fraud detection. This initiative, intended to reduce Medicare's vulnerability to fraud, involves an interagency agreement with the Department of Energy's Los Alamos National Laboratory. This 2-year \$6-million interagency agreement specifically calls for the development of prepayment antifraud methods that could be used to produce software suitable for inclusion in MTS. Because this effort is not expected to be completed until September 1997, it is too early to determine its effect on reducing Medicare fraud.

Finally, HCFA has also taken the initiative to strengthen Medicare's payment controls by awarding a \$1.6 million contract to test commercial software that detects billing abuse. In another 1995 study, we reported that commercially available software could improve HCFA's ability to prevent losses from inappropriately coded claims submitted for payment. In this study, a test using commercial software programs to detect code manipulation—one form of billing abuse—estimated that these programs could have reduced Medicare costs by over \$600 million annually for 1993 and 1994. HCFA's initial plans for this technology are to assess, customize, and test a commercial

software package at the Iowa Blue Cross and Blue Shield part B carrier to determine whether the software meets Medicare's needs and should be considered for inclusion at other sites and in MTS.

National Provider Identifier

HCFA has taken another important step to reduce Medicare's vulnerability to abusive billing and prevent fraudulent or excluded providers from continuing to bill the program. In May 1996, HCFA extended its existing system of physician identification numbers and registration procedures to new Medicare providers and suppliers. Medicare contractors are now required to verify professional and business license, certification, and registration information, and billing agency and subcontractor agreements. Contractors must also check each owning and managing employee against the HHS Inspector General's list of currently sanctioned providers and suppliers. Our earlier work identified problems with the completeness of this list, but, if corrected, this check should preclude fraudulent and incompetent providers from billing Medicare. HCFA will assign new identification numbers—National Provider Identifiers—to every provider and supplier in the Medicare program and, effective February 1997, will

require the use of these numbers for billing purposes. The numbers will be unique to each provider or supplier and will stay with them for the length of their Medicare participation regardless of relocations or changes in medical specialties.

Managed Care Program Risks

Most recent legislative proposals to reform Medicare would expand the program's use of prepaid health plans. Risk contract HMOs, Medicare's principal managed care option, are one version of these plans. They currently enroll about 10 percent of Medicare's population and have shown rapid enrollment growth in recent years. The Congressional Budget Office projects that, under one Medicare reform scenario, enrollment in risk HMOs and other prepaid plans could grow to 25 percent of all Medicare beneficiaries by 2002. Because prepayment of health benefits has helped private sector payers contain health care costs and limit the excess utilization encouraged by fee-for-service reimbursement, prepaid plans have cost-control appeal for Medicare, while offering potential advantages to beneficiaries.

However, our recent studies reveal shortcomings in Medicare's risk contract program that affect both taxpayers and beneficiaries. First, due to difficulties in establishing capitation rates, Medicare each year overpays some HMOs, thereby needlessly spending at least hundreds of millions of dollars annually from the program's trust funds. Second, HCFA has not adequately

enforced or kept beneficiaries apprised of HMOs' compliance with federal standards and other pertinent information about HMOs.

**Growing
Enrollment in
HMOs
Compounds
Problem of
Excessive
Payments**

The Medicare risk contract program is designed to limit the federal government's financial liability for covering health care costs. To do this, Medicare pays the risk HMOs it contracts with a flat, per-beneficiary fee, regardless of whether the HMO spends more or less for each enrollee's care. This capitated payment method breaks the linkage between payment and usage. However, a deficiency in Medicare's formula for setting HMO payment rates keeps the government from realizing managed care's potential savings. As with most financing problems, the devil is in the details; a simplified view of the problem follows.

HMOs tend to attract Medicare beneficiaries whose need for costly care when joining is low. In this way, HMOs are said to attract a "favorable selection" of Medicare beneficiaries. The formula includes a crude "risk adjustor" to correct for favorable selection, but it is not precise enough to account for its full effect. HCFA analysts as well as independent researchers acknowledge this problem, and studies of

the favorable selection phenomenon have been conducted for over a decade. However, determining exactly how much less costly new HMO enrollees are compared to fee-for-service beneficiaries is difficult and complicated, thwarting efforts to devise a formula that will make adjustments precise enough to reflect enrollees' better health status.

When several studies reporting this problem appeared roughly a decade ago, less than 3 percent of Medicare beneficiaries were enrolled in risk contract HMOs. Today, however, such enrollment is much higher and in some parts of the country, growing rapidly. In just 2 years—between August 1994 and August 1996—the number of risk HMOs nationwide rose from 141 to 229 and enrollment in these HMOs grew by over 80 percent, from about 2.1 million to 3.8 million beneficiaries.

Research on improved payment methods has failed to develop an administratively feasible system of adjusting payments to eliminate the problem of excessive payments. However, in a forthcoming report we discuss a method that would at least lower the excess payments made to some HMOs. Unlike other formula adjustment methods being

developed today, this method is one that HCFA could implement right away. It is not designed to eliminate all the excess paid to each HMO for their healthier-than-average beneficiaries. Therefore, HCFA's implementation of this method would not likely result in underpaying any one HMO. Immediate implementation could save Medicare hundreds of millions of dollars annually.

**HCFA Has Been
Lax in Enforcing
HMO
Requirements,
While Not
Keeping
Beneficiaries
Adequately
Informed**

In 1995, we reported on the need for HCFA to be a more active agent for beneficiaries enrolling in Medicare HMOs. Despite efforts to improve its HMO monitoring, HCFA conducted only paper reviews of HMOs' quality assurance plans, examining only the description rather than the implementation of HMOs' quality assurance processes. Moreover, the agency was reluctant to take action against HMOs that subjected beneficiaries to abusive sales practices, unduly delayed beneficiaries' appeals of HMOs' decisions to deny coverage, or exhibited patterns of poor quality care.

Historically, HCFA has been unwilling to place sanctions against HMOs, even those it cites repeatedly for violations found during site monitoring visits. In 1988, 1991, and 1995, we

reported on the agency's pattern of ineffective oversight of HMOs violating federal standards. In the case of one Florida HMO, for example, HCFA found—in 1991, 1992, 1994, and 1996—some combination of deficiencies in marketing, enrollment, quality assurance systems, grievance and appeals procedures, and access to health services. Despite the repeated findings of standards violations at this HMO, HCFA's strongest regulatory action was to require, after each inspection, a corrective action plan.

HCFA also misses the opportunity to supplement its regulatory efforts by not keeping the Medicare beneficiary population well-informed about competing HMOs. As we reported in 1996, HCFA has a wealth of data, collected for program administration and contract oversight purposes, that it does not package or disseminate for consumer use. For example, HCFA does not provide beneficiaries with any of the comparative consumer guides that the federal government and other employer-based health insurance programs routinely distribute to their employees and retirees. Such guides are typically summary charts comparing the benefit packages and premium rates of available area plans. Instead, HCFA collects information only for

its internal use—records of each HMO's premium requirements and benefit offerings, disenrollment data (monthly reports specifying for each HMO the number of beneficiaries that joined and left that month), records of enrollees' complaints, and results of certification visits to HMOs.

Public disclosure of such comparative information as disenrollment rates could help beneficiaries choose among competing HMOs and encourage HMOs to do a better job of marketing their plans and serving enrollees. Because Medicare beneficiaries enrolled in HMOs can, each month, switch plans or return to fee-for-service, comparing plans' disenrollment rates can suggest beneficiaries' relative satisfaction with competing HMOs. Our 1996 analysis of HCFA's disenrollment data showed that Medicare HMOs' ability to retain beneficiaries varied widely among HMOs in the same market.

The substantial variation we found in the rate at which beneficiaries disenrolled from plans within the first 3 months of joining suggested that some HMOs do a better job than others of representing their plans to potential enrollees. Similarly, the HHS Inspector General found, in a 1991 study of one market's plans, that beneficiaries from

the plan with the highest rate of disenrollment within a year were much more likely than other plans' enrollees to misunderstand either that they were in an HMO or that they were restricted in provider choice.

New Health Insurance Act, Other Initiatives Intended to Address Risk Contract Program Problems

HCFA acknowledges the problems that persist in Medicare's risk contract program. To tackle the difficulties in setting capitation rates, HCFA has been conducting several demonstration projects that examine ways to modify or replace the current method of determining HMO payment rates. In addition, the Health Insurance Portability and Accountability Act amended HCFA's sanction authority in cases where HMOs have not complied with federal standards. Finally, HCFA is developing several consumer information efforts, including the dissemination of comparative information on competing HMOs, a beneficiary satisfaction survey, and a requirement for HMOs to report on aspects of patient care.

Table 2: Summary of Major Government Initiatives to Improve Medicare Managed Care

Problem area	Actions taken
HMO payment rates	HCFA demonstrations underway to improve risk adjustment or find alternative HMO payment methods include (1) research on two health status measures to determine their potential to account more precisely for favorable selection and (2) proposed use of competitive bids to establish HMO payment rates; now seeking a test site.
Efforts to regulate HMOs	Health Insurance Portability and Accountability Act: clarifies and extends the conditions under which HCFA can impose intermediate sanctions.
Publication of comparative information on competing HMOs	<p>HCFA plans electronic posting of comparative information.</p> <p>HCFA is developing standard member satisfaction survey that some HMOs are required to administer as of January 1997.</p> <p>Independent HMO industry organization has developed Medicare-specific clinical effectiveness measures of HMO performance; HCFA requires HMOs, as of January 1997, to report data related to these measures; HCFA intends to publish results.</p>

**Health Insurance
Portability and
Accountability Act**

The Health Insurance Portability and Accountability Act gives HCFA more flexible sanction authority while providing HMOs the statutory right to greater procedural safeguards. In addition to existing authority to terminate an HMO's contract if the HMO did not meet requirements, HCFA now has the option of imposing lesser sanctions, such as suspending the HMO's right to enroll Medicare beneficiaries until the deficiencies are corrected. Before imposing a sanction,

however, HCFA is required to provide the HMO with a reasonable opportunity to develop and implement a corrective action plan. Before the act made this a requirement, HCFA routinely requested corrective action plans of HMOs that violated federal standards.

Electronic Posting of
Comparative
Information

HCFA has plans to produce HMO comparison charts that will initially specify HMO costs and benefits covered and later may also include other plan-specific information—such as the results of HMOs’ satisfaction surveys. HCFA expects advocates and insurance counselors, not beneficiaries, to be the primary users of this information. HCFA plans to make the charts “available to any individual or organization with electronic access,” because “the materials will primarily reside in an electronic format, which is easily updatable and economical.” Providing the information in an electronic format, however, rather than in print, may make it less accessible to the very individuals who would find it useful. The information, according to HCFA, will have to be “downloaded and customized for local consumption.”

Beneficiary
Satisfaction Survey

HCFA is developing a standard survey, through HHS' Agency for Health Care Policy and Research, to obtain beneficiaries' perceptions of their managed care plans. This effort aims to standardize surveys and report formats to yield comparative information about, for example, enrollees' experiences with access to services, interactions with providers, continuity of care, and perceived quality of care. HCFA does not expect preliminary results before the end of 1997.

Other
Consumer-Oriented
Information
Initiatives

HCFA is working with the managed care industry, other purchasers, providers, public health officials, and consumer advocates to develop a new version of the Health Plan Employer Data and Information Set (HEDIS 3.0) that will incorporate measures relevant to the elderly population. The measures will enable comparisons to be made among plans of the enrollees' use of such prevention and screening services as flu shots, mammography, and eye exams for diabetics. As of January 1997, Medicare HMOs are required, from the time they renew their contract, to report on HEDIS 3.0 clinical effectiveness measures. HCFA intends to summarize the results and include them in comparability charts being developed. HCFA

is also working with the Foundation for Accountability, an independent organization composed of consumers and public and private health care payers, to develop more patient-oriented measures of health care quality. This may require new data collection efforts by plans, and its implementation may therefore be years away.

What Needs to Be Done

Adequate funding of anti-fraud-and-abuse activities coupled with strong HCFA oversight of its fee-for-service and managed care contracts constitute the foundation for managing a program that is permanently vulnerable to exploitation. The Health Insurance Portability and Accountability Act puts the cornerstone of this foundation in place by providing HCFA an opportunity both to stabilize its scrutiny of Medicare claims and more effectively regulate risk contract HMOs. In addition, the successful implementation of MTS is expected to help address various Medicare problems, including better controls over fraud and abuse. However, HCFA needs to mitigate the risks associated with the acquisition of this system. As HCFA faces this challenge as well as those presented by the growing and complex Medicare program, it needs to apply continued vigilance over day-to-day operations, make additional technological improvements, and exhibit strong leadership to effectively manage the program, thereby controlling the risks to both the taxpayers and beneficiaries.

Related GAO Products

Medicare Fee-for-Service

Fraud and Abuse: Providers Excluded From Medicaid Continue to Participate in Federal Health Programs (GAO/HEHS-96-205, Sept. 5, 1996).

Medicare: Private Payer Strategies Suggest Options to Reduce Rapid Spending Growth (GAO/T-HEHS-96-138, Apr. 30, 1996).

Medicare: Home Health Utilization Expands While Program Controls Deteriorate (GAO/HEHS-96-16, Mar. 27, 1996).

Medicare: Millions Can Be Saved by Screening Claims for Overused Services (GAO/HEHS-96-49, Jan. 30, 1996).

Fraud and Abuse: Providers Target Medicare Patients in Nursing Facilities (GAO/HEHS-96-18, Jan. 24, 1996).

Medicare Transaction System: Strengthened Management and Sound Development Approach Critical to Success (GAO/T-AIMD-96-12, Nov. 16, 1995).

Fraud and Abuse: Medicare Continues to Be Vulnerable to Exploitation by Unscrupulous Providers (GAO/T-HEHS-96-7, Nov. 2, 1995).

Medicare Spending: Modern Management Strategies Needed to Curb Billions in Unnecessary Payments (GAO/HEHS-95-210, Sept. 19, 1995).

Medicare: Antifraud Technology Offers Significant Opportunity to Reduce Health Care Fraud (GAO/AIMD-95-77, Aug. 11, 1995).

Medicare: Excessive Payments for Medical Supplies Continue Despite Improvements (GAO/HEHS-95-171, Aug. 8, 1995).

Medicare: Allegations Against ABC Home Health Care (GAO/OSI-95-17, July 19, 1995).

Medicare: Commercial Technology Could Save Billions Lost to Billing Abuse (GAO/AIMD-95-135, May 5, 1995).

Medicare and Medicaid: Opportunities to Save Program Dollars by Reducing Fraud and Abuse (GAO/T-HEHS-95-110, Mar. 22, 1995).

Medicare: High Spending Growth Calls for Aggressive Action (GAO/T-HEHS-95-75, Feb. 6, 1995).

Medicare: Inadequate Review of Claims Payments Limits Ability to Control Spending (GAO/HEHS-94-42, Apr. 28, 1994).

Medicare: Greater Investment in Claims Review Would Save Millions (GAO/HEHS-94-35, Mar. 2, 1994).

Medicare: New Claims Processing System Benefits and Acquisition Risks (GAO/HEHS/AIMD-94-79, Jan. 25, 1994).

**Medicare
Managed Care**

Medicare: HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance (GAO/HEHS-97-23, Oct. 22, 1996).

Medicare Managed Care: Growing Enrollment Adds Urgency to Fixing HMO Payment Problem (GAO/HEHS-96-21, Nov. 8, 1995).

Medicare: Increased HMO Oversight Could Improve Quality and Access to Care (GAO/HEHS-95-155, Aug. 3, 1995).

Medicare: Changes to HMO Rate Setting Method Are Needed to Reduce Program Costs (GAO/HEHS-94-119, Sept. 2, 1994).

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